Submission
No 248

INQUIRY INTO BIRTH TRAUMA

Organisation: Transforming Maternity Care Collaborative and Australian Midwifery and Maternity Alliance

Date Received: 15 August 2023

AMMA
AUSTRALIAN MIDWIFERY
& MATERNITY ALLIANCE

Transforming
Maternity Care
COLLABORATIVE

Submission to the New South Wales (NSW) Inquiry into Birth Trauma

This is a joint submission from the Australian Midwifery and Maternity Alliance and Transforming Maternity Care Collaborative**.**

The **Australian Midwifery and Maternity Alliance** (AMMA) is a national group of midwifery academics, researchers, clinicians, and maternity consumers focused on improving universal primary maternity care for Australian women and their families. Our work aims to strategically enable evidence informed policy and practice resulting in high quality, maternity services.

Transforming Maternity Care Collaborative (TMCC) is an Australian based, international collaboration of maternity related practitioners, researchers, educators, policy makers, maternity consumer groups, and community organisations. We share a common goal to support the reform of maternity services to provide universal access to a primary care model that is midwife-led in the community, accessible, and respects women's choices. TMCC objectives include generating evidence about the benefits of midwifery continuity of care, fostering partnerships to implement maternity system reform, partnering with community-level agencies and groups to implement woman-centred care in their own communities.

There is a significant body of evidence about birth trauma; much of it generated by Australian researchers within AMMA and/or TMCC including:

- *Professor Emeritus Debra K Creedy* who first documented prevalence and contributing factors in the Australian context in 2000.
- *Dr Hazel Keedle and Professor Hannah Dahlen* who demonstrated through the *Birth Experience Study* that the model of care women access has a direct impact on whether they experience a traumatic birth, and the level of obstetric violence and mistreatment they endure.
- *Professor Emeritus Jenny Gamble* who developed and tested a counselling intervention to mitigate trauma symptoms following traumatic childbirth.
- *Dr Jocelyn Toohill* who investigated fear of birth and relationship to traumatic childbirth.

Our submission addresses the Select Committee's **Terms of Reference (ToR) A, B, E, F, H.** Lettered headings throughout the submission aligns with the relevant ToR. The terms "birth trauma" and "obstetric violence" are used interchangeably. **Our recommendations to the Select Committee are:**

1) Improve access to freestanding birth centres and publicly funded homebirth programs across NSW.
2) Amend the Private Health Facilities 2017 (NSW) regulation to allow Birthing on Country facilities to be implemented across NSW.
3) Develop education programs to assist both healthcare professionals and childbearing women to understand women's right to bodily autonomy and informed choice in maternity care.
4) Establish a Chief Midwife role in NSW, to prioritise, strategise, and lead the implementation of midwifery continuity of carer models.
5) Resolve local barriers to private midwives obtaining hospital visiting rights in NSW.
6) Fund a NSW public health campaign to inform women of the availability and benefits of midwifery continuity of carer.
7) Implement bundled funding for maternity care to reduce fragmentation, duplication, unnecessary intervention, and over-servicing.
8) Mandate health services to monitor and report on informed consent processes and compliance in relation to procedures in labour and birth to ensure choice and protect women's human rights.

A) The experience and prevalence of birth trauma

Birth trauma refers to psychological injuries that occur during childbirth. One-third of birthing women report birth as traumatic.[1] The prevalence of traumatic childbirth has been consistent over the last 20+ years.[2-4] Women who have been exposed to obstetric violence experience emotional distress due to lack of control, lack of support, and lack of communication.[5] Negative healthcare provider interactions create feelings of powerlessness and loss of control which contributes to experiencing birth as traumatic.[6]

Traumatic birth can lead to poor and declining mental health postpartum. Postpartum mental health disorders associated with traumatic birth include acute post-traumatic stress and post-traumatic stress disorder involving feelings of guilt, shame, anger, negative alteration in mood and cognition, an altered sense of self, feelings of helplessness and dread for the future.[7] Mother-child bonding and difficulties in the spousal relationship are commonly reported. The negative impact on mother-infant bond disrupts infant mental, emotional, and social developmental.[6,8] Severe cases of birth trauma can lead to maternal suicidal ideation or maternal neonaticide.[7] The experience of birth trauma can negatively influence women's reproductive choices with some women avoiding future pregnancy or electing to give birth by caesarean section. Some women choose to freebirth which means they give birth without the presence of any health professional.[9]

B) Causes and factors contributing to birth trauma

Birth trauma is a multifaceted and complex issue, its causes are often interconnected and predominately stems from obstetric violence. Obstetric violence refers to harm inflicted during the childbearing experience that arises from the normalised abusive actions of healthcare providers.[10]

B1. Overuse of obstetric intervention and the medicalisation of childbirth

Birth trauma is related to obstetric interventions.[3,4,11] In NSW the caesarean section rate is 37.6%, and the induction of labour rate is 35.5%.[12] These rates are at an all-time high without concomitant improvement in maternal or newborn outcomes. Over the last decade, the episiotomy rate (a cut to the vaginal opening) has almost doubled with 1 in 4 women in NSW experiencing this intervention.[12] Unnecessary and overused medical interventions have been normalised. The Editor of The Lancet (2018) describes the unprecedented and unjustified rise in caesarean section rates as an "epidemic".[13]

B2. Normalising of abusive care

Normalised abuse in maternity care is common – it is a global problem[14] – including in Australia.[1] It manifests as unconsented interventions, coercion to accept interventions, disrespect (e.g., dismissing and disregarding needs and preferences, bossing and bullying, and infantilising), physical abuse and assault.[15] Midwifery students report having to collude in obstetric violence such as forcing women's legs open for unconsented vaginal examinations and episiotomies which may be framed as "simply part of the training".[16]

B3. Well women are routinely hospitalised for labour and birth

In NSW in 2021 only 0.3% of women had a homebirth and only 2.9% gave birth in a birth centre.[12] While choice of birth setting is at the heart of woman-centred care, most women in NSW do not have a choice. There are approximately six publicly funded homebirth programs statewide, and limited places available in birth centres. Unmet consumer demand for choice of birth place is evidenced by lengthy waitlists for both options.

Homebirth

Quality evidence shows homebirth to be a safe and preferrable option to hospital birth for well mothers and babies, who experience fewer complications and interventions compared to birth in hospital. In high-

income countries, for selected women at low risk of perinatal complications, planned homebirth at onset of labour is associated with:

- similar or better outcomes for mothers and babies[17-20]
- higher levels of childbirth satisfaction[21]
- fewer iatrogenic events related to overuse of medical interventions[17,19,20]

Table 1 presents maternal outcomes from the 2021 meta-analysis of planned homebirth at onset of labour compared to planned hospital birth conducted by Safer Care Victoria.[22]

Table 1. Maternal outcomes of planned homebirth compared to planned hospital birth

Outcome	No. studies	Risk ratio	95% CI	Risk ratio	95% CI	Interpretation
		Nulliparous women		Multiparous women		
Unassisted vaginal birth	5	1.13	1.03 to 1.24	1.04	0.98 to 1.10	More likely for nulliparous women who plan homebirth
Instrumental birth	4	0.63	0.47 to 0.86	0.34	0.16 to 0.74	Less likely for women who plan homebirth
Unplanned caesarean	5	0.72	0.53 to 0.99	0.30	0.13 to 0.66	Less likely for women who plan homebirth
Severe perineal trauma	5	1.08	0.57 to 2.04	0.62	0.50 to 0.76	Less likely for multiparous women who plan homebirth
Manual removal of the placenta	2	0.97	0.89 to 1.06	0.50	0.27 to 0.95	Less likely for multiparous women who plan homebirth
Postpartum haemorrhage >=500 mL	2	0.68	0.51 to 0.91	0.43	0.19 to 0.95	Less likely for women who plan homebirth
Postpartum haemorrhage >=1000 mL	4	1.00	0.93 to 1.08	0.54	0.48 to 0.62	Less likely for multiparous women who plan homebirth

Homebirth reduces the risk that well mothers and babies will experience birth trauma from unnecessary medical intervention and associated complications.

Freestanding birth centres

A Level 2 maternity service (freestanding birth centre) provides midwifery care to low risk women and babies, with seamless transfer procedures to access higher level medical services if required.[23] There is strong empirical evidence from Australia, England, and New Zealand that birth centres provide safe and beneficial perinatal care for women classified as low-risk,[24-26] including in rural and very remote areas.[27-32] Conversely, women who plan to give birth in a tertiary maternity hospital are more likely to suffer physical harm including episiotomy and caesarean section, than those who plan to give birth in a birth centre.[33] Freestanding birth centre care reduces the risk the well mother and babies will experience birth trauma from unnecessary medical intervention and associated complications.

Recommendation 1: Improve access to freestanding birth centres and publicly funded homebirth programs across NSW.

B4. Birthing on Country facilities for First Nations women are obstructed by NSW law

The Birth Experience Study reported that Aboriginal and/or Torres Strait Islander women have some of the highest rates of birth trauma at 37% compared to 28% for all women; furthermore, 1 in 6 First Nations women say they have experienced OV compared to 1 in 10 women overall.[34]

Birthing on Country

First Nations women and their babies in NSW have limited access to **Birthing on Country (BoC).** Birthing on Country is a metaphor for best start to life – it provides cultural safety, is holistic and respectful.[35] Birthing on Country models are designed so that First Nations women and families experience high level of social and

emotional wellbeing during their childbearing experience, and their babies are born healthy and strong.[36] Gold standard Birthing on Country models include midwifery continuity of care, cultural support provided by a First Nations health worker, integrated trauma-informed services, and a First Nations governed birth centre for women at low risk of complications.[37] In NSW, only one birth centre facility is planned in Nowra, by Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation. Significantly, only one is possible - due to structural barriers embedded in *Private Health Facilities Regulation 2017* (NSW)[38] which states that the Level 2 maternity facility providing intrapartum care must have:

> *"38. Normal risk pregnancies*
> *(a) obstetricians, anaesthetists, and a paediatrician on call at all times*
> *(b) a medical practitioner **at the facility at all times**"*[38]

This requirement directly contradicts the National Clinical Capability Framework[23] which recommends lower capability services *transfer* to higher capability services to access medical practitioners and that they are not required to be on-call or on-site at the birth centre. While the *Private Health Facilities Amendment (Birthing on Country Demonstration Facilities) Regulation 2023* (NSW)[39] allows for one facility to be exempt from these requirements, the 2017 Regulation acts as a barrier to any other BoC facility in NSW meeting private licensing standards and therefore limits First Nations women's access to a culturally and clinically safe model of care.

Recommendation 2: Amend the Private Health Facilities 2017 (NSW) regulation to allow Birthing on Country facilities to be implemented across NSW.

E) The role and importance of "informed choice" in maternity care

Bodily autonomy and informed choice are fundamental human rights[40] reflected in the Australian Charter of Health Care Rights[41]. The importance of informed choice and consent is reflected in Professional Codes of Conduct and the National Safety and Quality Health Service Standards, linked with legislation and best practice. Recognition of the right to bodily autonomy underpins the informed choice and consent process in healthcare.

Women have the right to make free and uncoerced decisions about their body and health at any time (including during pregnancy). Women have a right to be informed of the risks, benefits, and alternatives to any proposed treatment or procedure, and to then agree to or decline a recommend plan of care. "Informed choice" as the name implies, must include both elements of "informed" and "choice". A 2023 survey of Australian midwifery students reports that consent during labour and birth is often invalid due to lack of disclosure of risks and alternatives.[42] If women are not informed with the best available evidence in a way that is unbiased, and if they are not made aware of the limitations of the evidence (quality and possible longer-term implications of a procedure for example), then their decisions will not be informed. If alternative management plans are not canvassed, if women's values, concerns, and opinions are not elicited, if women are coerced to consent, or informed that they have a right to decline care then there it is not "choice" but acquiescence to a plan or procedure that has been decided for them. Informed choice is a condition of consent.

The power dynamics, vulnerability of women in need of maternity care, the misogynist attitudes and lack of respect for women, that permeate maternity settings and create the "norms" in which healthcare professionals operate, make it almost impossible for women to engage in genuine informed decision making [43]. Indeed, coercion is ubiquitous in our maternity services. When women's birth intentions do not align with clinicians preferences, a range of strategies may be used to convince the woman to accept recommended care.[44] Strategies include "playing the dead baby card"; where healthcare professionals overstate the risk to a woman and or her baby, often misrepresenting the evidence in order to secure agreement to a procedure, "cherry picking" evidence that aligns with the healthcare professional's view,

threats to withdraw care if the woman does not agree to a procedure, and threats to involve child protection services if a woman does not agree to an unwanted procedure for herself or her baby.[44,45]

Women's right to bodily autonomy is routinely ignored as it is the healthcare provider who most often decides in which circumstance, informed choice or consent is needed. A 2023 Australian survey of midwifery students reports that obstetric interventions are commonly presented as ''routine care" which undermines women's choices in favour of provider preferences.[42] Written consent is often reserved for operative procedures such as caesarean section while many women report lack of choice or consent for vaginal examinations or episiotomies.

Many choices in maternity care are not time critical and can be revisited over many weeks and months with an informed decision emerging within the context of a trusting and respectful relationship between the childbearing woman and healthcare professional.[46] For most decisions, informed choice is a process not a one-off event.[47] In emergency situations a skilled healthcare professional can assist women to make informed decisions and retain a sense of bodily autonomy and control.

Recommendation 3: ***Develop education programs to assist both healthcare professionals and childbearing women to understand women's right to bodily autonomy and informed choice in maternity care.***

F) Barriers to the provision of "continuity of care" in maternity care

Midwifery continuity of care (also known as midwifery group practice, continuity of midwifery carer or caseload midwifery care) provides continuous care led by the same midwife from the first booking visit in pregnancy to labour and, birth and the early postpartum period; in collaboration with other care providers as clinically indicated. Midwifery continuity of care facilitates a close and trusted relationship between a woman and her midwife and contributes to greater engagement in maternity care.[48] A systematic review and meta-analysis of 15 randomised controlled trials including >17,000 women demonstrates midwife continuity of care saves lives, reduces morbidity and enhances the health of women and babies compared with other models of care.[49] Despite the compelling evidence, roll out and scale up of these models has been slow and inconsistent across and within jurisdictions. Nationally only 15% of women are provided with midwifery continuity of care.[50]

F1. Nurses have decision-making authority over midwifery

National Law specifies that midwifery is a distinct and separate profession from nursing (i.e., it is not a speciality of nursing), yet senior managers of midwives are usually nurses.

Consequently, at the Commonwealth and State Levels of Government, midwives are structurally restricted from making decisions about midwifery workforce, regulation, and education issues. Instead, the governance structure privileges the role of Chief Nurse to make decisions about midwifery. This limits midwives' ability to drive evidence-based practice, and in particular, to improve women's access to midwifery continuity of care models. The implementing midwifery continuity of midwifery care has predominantly driven by local midwifery leadership, which makes it fragile and reduces scale up opportunities.

Recently (2023) the Midwifery Advisory Group of the Council of Deans of Nursing and Midwifery (ANZ) published a Position Paper: The future of the midwifery workforce in Australia recommended: *The Australian, State and Territory Governments should each appoint a Chief Midwife.*[51] Midwifery leadership is critical to successful and sustainable implementation of midwifery continuity of care models. Midwifery leadership would be a key driver to have midwifery continuity of care reflected in policy with a strategy and a plan for implementation.

Recommendation 4: Establish a Chief Midwife role in NSW, to prioritise, strategise, and lead the implementation of midwifery continuity of carer models.

F2. Private midwifery practice is cumbersome in New South Wales

Privately practising midwife (PPMs) providing midwifery continuity of care achieved the lowest rates of birth trauma of any of the models during the COVID-19 pandemic.[34] Together, midwifery group practice and private midwifery practice achieved the highest continuity, lowest birth trauma rates, lowest rates of birth intervention, and highest level of sustained postnatal care.[34] Despite this, there continues to be lack of support for PPMs in NSW. There is only one maternity facility in NSW that provides visiting access for PPMs. The barrier is misalignment between local policies across local health districts, and legislation which supports private midwifery practice. The highly skilled, endorsed, and motivated workforce of PPMs, providing midwifery continuity of care, remain under-utilised.

Recommendation 5: Resolve local barriers to private midwives obtaining hospital visiting rights.

F3. Most women are unaware of midwifery continuity of carer and don't know to ask for it

Women provided with fragmented and medicalised care consistently report that their experience of care across pregnancy, labour, and birth and in the early days of mothering was dehumanising.[1] Women receiving relationship-based midwifery continuity of care report greater levels of emotional safety, support, and empowerment through improved health literacy and trust that their midwife will respect and advocate for their decisions.[52] A 2023 integrative review concludes that some women perceive they have no choice in the model of care they are allocated, while others recall they were not provided with information about all available models of care.[53] Few women are offered the option of midwifery continuity of midwifery care, or to know to ask for it.

Recommendation 6: Fund a NSW public health campaign to inform women of the availability and benefits of midwifery continuity of carer.

F4. Activity based funding models incentivise intervention

Most maternity care funding is activity based meaning the more episodes of care provided the more funding the health services receives. Complex care such as caesarean section and longer than average postnatal inpatient stay costs more, and therefore attract greater funding, than normal birth with a shorter postnatal inpatient stay. This system provides financial incentive to prioritise service volume over consumer outcomes and disincentivises approaches to care that are cost-effective, such as midwifery continuity of care. Midwifery continuity of carer models deliver cost savings of up to 22% for health services alongside contributing to significantly better outcomes.[54] This cost saving is largely due to lower rates of intervention, operative birth, and inpatient stays.[54,55]

Bundled funding is used in other countries that provide greater access to midwifery continuity of carer (e.g., New Zealand). In these models, services are provided a single payment which covers all the care provided to a woman throughout pregnancy, intrapartum, and postnatally. In this way, bundled funding provides costs savings for services who provide care most efficiently, rather than rewarding those who deliver the most episodes and highest-cost procedures. Evidence suggest that bundled payments lead to increased coordination of care, enhanced quality of care and less fragmentation across the health system.[56]

Recommendation 7: Implement bundled funding for maternity care to reduce fragmentation, duplication, unnecessary intervention, and over-servicing.

H) Whether current legal and regulatory settings are sufficient to protect women from experiencing birth trauma

There is no legal service for obstetric violence, and there is no law against it. There are anecdotal case reports that the police have no interest in investigating, or recording, any complain of assault in the context of maternity care provision. Similarly, the Health Care Complaints Commission refuses to investigate complaints around mistreatment unless there is long term harm (e.g., women reporting a non-consented vaginal/anal exam are not provided with any recourse).

Current maternity indicators do not adequately measure outcomes from a woman's perspective. Additionally, they do not ascertain women's experiences of their maternity episode and how this may impact their physical, emotional, and parenting abilities. Informed consent is required for all medical interventions, tests and procedures in pregnancy and birth in Australia, however there are no national guidelines or frameworks that delineate the level of consent (implied, oral, or written) required for different interventions during pregnancy, birth and postpartum. NSW Health has published a one-page document to guide clinicians regarding informed consent, however, fail to stipulate what procedures require written versus oral versus implied consent.[57] The Australian Commission on Safety and Quality in Health Care state that all hospitals are required to have informed consent processes in alignment with Standard two, partnering with consumers.[58] Despite this broad recommendation, there is minimal guidance on how this is applied and monitored in pregnancy and labour. For example, although written informed consent is required for operative births in theatre (e.g., for caesarean section), there is no guidance on what procedures require written informed consent in the context of antenatal and intrapartum care. Furthermore, there is no requirement for hospitals to monitor and report on informed consent within the context of labour and birth. National consensus and clear regulations are therefore required to ensure that informed consent, whereby the woman understands the benefits and risks of the procedure, is obtained prior to any procedure in the context of birth (excluding life-threating situations such as massive obstetric haemorrhage).

Recommendation 8: Mandate health services to monitor and report on informed consent processes and compliance in relation to procedures in labour and birth to ensure choice and protect women's human rights.

In summary, effectively addressing birth trauma will have short, medium, and long-term benefits for women, their babies, and families. Although the Select Committee Inquiry into Birth Trauma is rightly largely focussed on the needs of women and their families, the health sector will also benefit by addressing birth trauma in terms of cost savings and retaining midwives.

We have made **8** recommendations. However, recommendations 1,2,4 and 5, all relate to scaling up of midwifery continuity of care. Recommendation 6 is focussed on ensuring women know of the benefits of this model compared to other models of care.

Increasing access to midwifery continuity of care has been recommended as a complex intervention to address current failures in maternity care.[59] Providing universal access for women to midwifery continuity of care would align maternity care with the best evidence, humanise birth and provide the platform for trauma-informed care.

15 August 2023

References

1. Keedle K, Keedle W, Dahlen H. Dehumanized, violated, and powerless: an Australian survey of women's experiences of obstetric violence in the past 5 years. *Violence Against Women* 2022; (Online ahead of print).
2. Alcorn K.L., O'Donovan A, Patrick JC, Creedy D, Devilly GJ. A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events. *Psychological Medicine* 2010; **40**(1): 1849-59.
3. Creedy D, Shochet I, Horsfall J. Childbirth and the development of acute trauma symptoms. *Birth* 2000; **27**(2): 104-11.
4. Gamble J, Creedy D, Moyle W, Webster J, M. M, P. D. Effectiveness of a counselling intervention following a traumatic childbirth: A randomized controlled trial. *Birth* 2005; **32**(1): 11-9.
5. Keedle H, Bell MV, Keedle MW, Dahlen H. O79 - Factors contributing to women's experiences of birth trauma in Australia. *Women and Birth* 2022; **35**: 31.
6. Watson K, White C, Hall H, A. H. Women's experiences of birth trauma: A scoping review. *Women and Birth* 2021; **34**(5): 417-24.
7. Byrne V, Egan J, Mac Neela P, Sarma K. What about me? The loss of self through the experience of traumatic childbirth. *Midwifery* 2017; **51**: 1-11.
8. Zhang K, Dai L, Wu M, Zeng T, Yuan M, Chen Y. Women's experience of psychological birth trauma in China: a qualitative study *BMC Pregnancy and Childbirth* 2020; **20**(1).
9. McKenzie G, Robert G, Montgomery E. Exploring the conceptualisation and study of freebirthing as a historical and social phenomenon: A meta-narrative review of diverse research traditions. *Medical Humanities* 2020; **46**(4): 512-24.
10. O'Brien E, Rich M. Obstetric violence in historical perspective *The Lancet* 2022; **399**(10342): 2183-5.
11. Toohill J, Fenwick J, Sidebotham M, Gamble J, Creedy D. Trauma and fear in Australian midwives. *Women and Birth* 2018; **32**(1): 64-71.
12. Australian Institute of Health and Welfare. Australia's mothers and babies2023. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies (accessed 14 August 2023).
13. Editor. Stemming the global caesarean section epidemic. *The Lancet* 2018; **392**(10155): 1279.
14. White Ribbon Alliance. Respectful Maternity Care: The Universal Rights of Women and Newborns2022. https://whiteribbonalliance.org/wp-content/uploads/2022/05/WRA_RMC_Charter_FINAL.pdf (accessed 15 August 2023).
15. Hill EC. Midwives' perspectives of obstetric violence during childbirth (thesis): Western Sydney University; 2022.
16. van der Waal R, Mitchell V, van Nistelrooij I, Bozalek V. Obstetric violence within students' rite of passage: The reproduction of the obstetric subject and its racialised (m)other. *Agenda* 2021; **35**(3).
17. Reitsma A, Simioni J, Brunton G, Kaufman K, Hutton EK. Maternal outcomes and birth interventions among women who begin labour intending to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. *EClinicalMedicine* 2020; **21**: 100319.
18. Hutton EK, Reitsma A, Simioni J, Brunton G, Kaufman K. Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. *EClinicalMedicine* 2019; **14**: 59-70.
19. Scarf VL, Rossiter C, Vedam S, et al. Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: A systematic review and meta-analysis. *Midwifery* 2018; **62**: 240-55.
20. Rossi AC, Prefum F. Planned home versus planned hospital births in women at low-risk pregnancy: A systematic review with meta-analysis. *European Journal of Obstetrics & Gynecology and Reproductive Biology* 2018; **222**: 102-8.

21. Donate-Manzanares M, Rodríguez-Cano, T., Rodríguez-Almagro, J., Hernández-Martínez, A., Santos-Hernández, G., Beato-Fernández, L. Mixed-method study of women's assessment and experience of childbirth care. *Journal of Advanced Nusing* 2021; **77**(10): 4195-20.
22. Safer Care Victoria. Homebirth guidance - Evidence summary: A systematic review of outcomes for planned homebirth for low-risk women2021. https://www.bettersafercare.vic.gov.au/sites/default/files/2021-05/EVIDENCE%20SUMMARY_Homebirth.docx (accessed 31 March 2022).
23. Australian Health Ministers' Advisory Council. National Maternity Services Capability Framework. Department of Health and Aged Care; 2012.
24. Monk A, Tracy M, Foureur M, Grigg C, Tracy S. Evaluating Midwifery Units (EMU): a prospective cohort study of freestanding midwifery units in New South Wales, Australia. *BMJ Open* 2014; **4**(10): e006252.
25. Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 2011; **343**: d7400.
26. Davis D, Baddock S, Pairman S, et al. Planned place of birth in New Zealand: Does it affect mode of birth and intervention rates among low-risk women? *Birth* 2011; **38**(2): 111-9.
27. Kruske S, Schultz T, Eales S, Kildea S. A retrospective, descriptive study of maternal and neonatal transfers, and clinical outcomes of a Primary Maternity Unit in rural Queensland, 2009-2011. *Women and Birth* 2015; **28**(1): 30-9.
28. Scherman S, Smith J, Davidson M. The first year of a midwifery-led model of care in Far North Queensland. *Medical Journal of Australia* 2008; **188**(2): 85-8.
29. Van Wagner V, Epoo B, Nastapoka J, Harney E. Reclaiming birth, health, and community: midwifery in the Inuit villages of Nunavik, Canada. *Journal of Midwifery and Women's Health* 2007; **52**(4): 384-91.
30. Van Wagner V, Osepchook C, Harney E, Crosbie C, Tulugak M. Remote midwifery in Nunavik, Quebec, Canada: outcomes of perinatal care for the Inuulitsivik health centre, 2000-2007. *Birth* 2012; **39**(3): 230-7.
31. Leeman L, Leeman R. Do all hospitals need cesarean delivery capability? An outcomes study of maternity care in a rural hospital without on-site cesarean capability. *Journal of Family Practice* 2002; **51**(2): 129-34.
32. Kornelsen J, K M. The Safety of Rural Maternity Services without Local Access to Cesarean Section: Perinatal Services BC, University Centre for Rural Health, 2015.
33. Grigg CP, Tracy SK, Tracy M, et al. Evaluating Maternity Units: a prospective cohort study of freestanding midwife-led primary maternity units in New Zealand-clinical outcomes. *BMJ Open* 2017; **7**(8).
34. Keedle H, Dahlen H. Submission to the NSW Inquiry into Birth Trauma: Western Sydney University, 2023.
35. Kildea S, Magic-Dennis F, Stapleton H. Birthing on Country Workshop Report, Alice Springs, 4th July Brisbane: Maternity Services Inter-Jurisdictional Committee for Australian Health Ministers’ Advisory Council, 2013.
36. Kildea S, Lockey R, Roberts J, Magick-Dennis F. Guiding Principles for Developing a Birthing on Country Service Model and Evaluation Framework, Phase 1. Brisbane: Mater Medical Research Unit and the University of Queensland on behalf of the Maternity Services Inter-Jurisdictional Committee for the Australian Health Ministers’ Advisory Council, 2016.
37. Kildea S, Hickey, S., Barclay, L., Kruske, S., Nelson, C., Allen, J., Gao, Y., Blackman, R., Roe, Y. L., & Sherwood, J. . Implementing Birthing on Country services for Aboriginal and Torres Strait Islander families: RISE Framework. *Women and Birth* 2019; **32**(5): 466-75.
38. Private Health Facilities Regulation 2017 [NSW]. NSW Government; 2017.
39. Private Health Facilities Amendment (Birthing on Country Demonstration Facilities) Regulation 2023 [NSW]. New South Wales; 2023.
40. Kanem N. Bodily autonomy: A fundamental right. 2022. https://www.unfpa.org/press/bodily-autonomy-fundamental-

right#:~:text=Bodily%20autonomy%20means%20my%20body,all%2C%20it's%20a%20fundamental%20right. (accessed 14th August 2023).
41. Australian Commission on Safety and Quality in Health Care. Australian Charter of Healthcare Rights. Australian Commission on Safety and Quality in Health Care; 2020.
42. Lee N, Kearney L, Shipton E, et al. Consent during labour and birth as observed by midwifery students: A mixed methods study. *Women Birth* 2023.
43. Sacks E, Peca E. Confronting the culture of care: a call to end disrespect, discrimination, and detainment of women and newborns in health facilities everywhere. *BMC Pregnancy and Childbirth* 2020; **20**(1): 249.
44. Jenkinson B, Kruske S, Kildea S. The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis. *Midwifery* 2017; **52**: 1-10.
45. Reed R, Sharman R, Inglis C. Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy and Childbirth* 2017; **17**(1): 21.
46. Paterick ZR, Paterick TE, Paterick BB. Medical informed choice: understanding the element of time to meet the standard of care for valid informed consent. *Postgrad Med J* 2020; **96**(1141): 708-10.
47. New Zealand College of Midwives. Consensus Statement: Informed Consent and Decision Making 2016. https://www.midwife.org.nz/wp-content/uploads/2019/05/Informed-Consent-and-Decision-Making.pdf (accessed 14th August 2023).
48. Allen J, Kildea, S., & Stapleton, H. How optimal caseload midwifery can modify predictors for preterm birth in young women: Integrated findings from a mixed methods study. *Midwifery* 2016; **41**: 30-8.
49. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews* 2016; **4**: Cd004667.
50. AIHW. Maternity care in Australia: first national report on models of care, 2021. Australian Institute of Health and Welfare Canberra, Australia; 2021.
51. Council of Deans of Nursing and Midwifery Australia and New Zealand. The future of the midwifery workforce in Australia: Position Paper. 2023.
52. Allen J, Kildea S, Hartz DL, Tracy M, Tracy S. The motivation and capacity to go 'above and beyond': Qualitative analysis of free-text survey responses in the M@NGO randomised controlled trial of caseload midwifery. *Midwifery* 2017; **50**: 148-56.
53. Cutajar L, Dahlen HG, Leechburch Auwers A, et al. Model of care matters: An integrative review. *Women Birth* 2023; **36**(4): 315-26.
54. Callander E, Bull C, McInnes R, J. T. The opportunity cost of current birth models in Australia: Hospital resource savings for a post-COVID-19 era. *Birth* 2021; **48**: 274-82.
55. Tracy SK, Welsh A, Hall Bea. Caseload midwifery compared to standard or private obstetric care for first time mothers in a public teaching hospital in Australia: a cross sectional study of cost and birth outcomes. *BMC Pregnancy and Childbirth* 2014; **14**.
56. Independent Hospital Pricing Authority. Bundled pricing for maternity care: Final report of the IHPA and the Bundled Pricing Advisory Group. IHPA; 2017.
57. NSW Health. Consent requirements for pregnancy and birth. 2020.
58. Australian Commission on Safety and Quality in Health Care. Informed consent2023. https://www.safetyandquality.gov.au/our-work/partnering-consumers/informed-consent (accessed.
59. Allen J, Toohill J, Creedy DK, Callander EJ, Gamble J. Development of a co-designed, evidence-based, multi-pronged strategy to support normal birth. *Australian and New Zealand Journal of Obstetrics and Gynaecology* 2022; **62**(5): 790-4.